Overview of Texas Medicaid-CHIP MCO and DMO Value-Based Contracting Initiatives in 2016

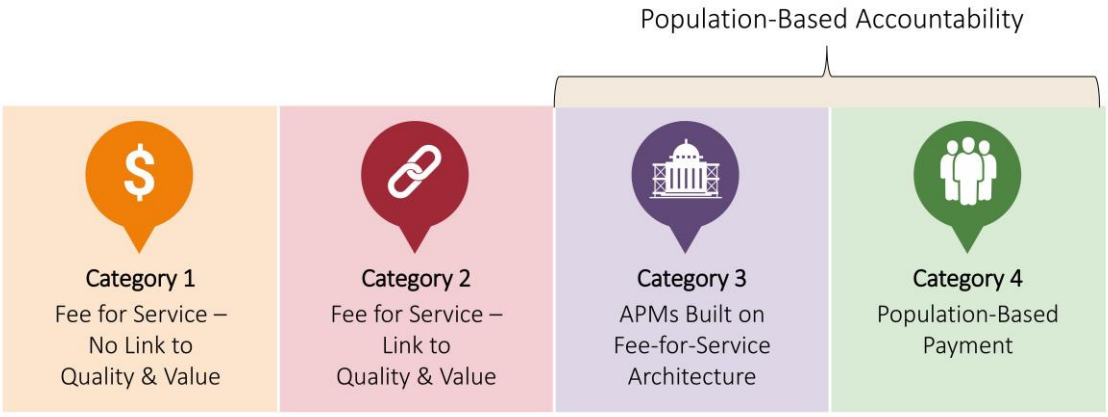
Introduction

There are multiple initiatives at national and state levels to move healthcare payments away from the customary volume-based fee-for-service (FFS) reimbursement model towards models that incentivize improved health care outcomes and increased efficiencies. In January 2015 the United States Department of Health and Human Services (HHS) set a goal of tying 30 percent of all traditional (FFS) Medicare provider payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs), Patient Centered Medical Homes (PCMH) or "bundled payment" arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018.[1] HHS also set a goal of tying at least 85 percent of all traditional (FFS) Medicare payments to quality and value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing[2] and the Hospital Readmissions Reduction Programs.[3]

These efforts go by various names, such as pay for performance (P4P), pay for quality (P4Q), value-based payments/purchasing (VBP), alternate payment models (APM), or value-based contracting (VBC). Texas at this time uses the term value-based contracting in its uniform managed care contract requirements.

As Medicaid-CHIP moves from volume-based payment to paying for value, HHSC would expect to see a gradual transition of payment models over the next few years following the Alternative Payment Models (APM) Framework (Figure 1).

Figure 1: APM Framework (At-a-Glance)



Source: Alternative Payment Model (APM) Framework and Progress Tracking Work Group

[1] http://www.hhs.gov/blog/2015/01/26/progress-towards-better-care-smarter-spending-healthier-people.html
[2] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing.html
[3] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HRRP/Hospital-Readmission-Reduction-Program.html

This framework has been created at the behest of CMS by the Health Care Payment Learning & Action Network. A more detailed view of the APM framework is available here, along with a white paper that explores the topic fully.

Overview of Submitted Plans

Texas HHSC requires all Medicaid-CHIP managed care organization (MCOs) and dental managed care organizations (DMOs) to submit an annual deliverable that details their various VBC initiatives. In 2016 all of Texas' 19 Medicaid-CHIP MCOs and both DMOs offer some form of VBC. For Texas Medicaid-CHIP health plans involved in the managed care model, value-based contracting approaches differ according to health plan size and level of VBC sophistication, composition/characteristics of provider network, geographic diversity, and beneficiaries' needs. The following is a summary of the reports received from the plans for 2016.

Geographic Diversity

In general, the VBC structures the MCOs implemented for their providers include all service delivery areas and programs in which they serve. The extent of geographic coverage depends on a plan's experience with payment reform. Some MCOs have had several years of experience and rolled out programs across larger geographic regions based on their successes, while other plans chose to start small with pilot programs. A smaller number of MCOs chose to be inclusive of their entire provider network within a service area and program. The local provider culture may also play a role in which VBC models expand within a region. It is well documented that primary care doctors are earning less than specialists, especially in regions where they are a common sight. Some managed care organizations started changing the way that doctors are paid and valuing primary care in a way that improves access and quality. For example, the Lower Rio Grande Valley and El Paso markets are known for expanded primary care clinic hours and walk-in appointments. In contrast, the Nueces region has a large penetration of the capitated model into primary care, so that the physicians can be paid on the number of members they are assigned.

Provider Types

The types of providers engaged in alternative payment structures proposed by MCOs varied. Some MCOs include all provider types in the network, while others have a limited type of providers that would serve a certain size of panel/membership. Minimum patient panel size is also a factor in participation in more sophisticated or risk-based VBC models. Examples would be using a FFS base with a bonus or a partial capitation model for small-to-medium size providers, with a fully capitated medical home or shared-savings ACO type of model for large multi-specialty practices. For one plan, qualifying providers must have a combined CHIP/STAR minimum panel size of 30 members. Another plan makes available to all physicians with a significant panel size and membership an incentive plan that encourages quality care. Other plans offer their physicians a fixed amount per-member per-month based on their panel size as an incentive for care coordination and management.

In addition to primary care providers such as family practice and general practice, specialist providers from internal medicine, Ob/Gyn, pediatrics, surgery, therapy services, durable medical equipment, and pharmacies were involved in the new VBC arrangements. In some instances, the type of providers and services selected in the alternative payment models were influenced by MCO clinical (e.g. preventive versus acute care) and administrative priorities.

The number of providers participating in different MCO incentive programs often varied depending on whether the providers were engaged individually or in group practices. The number of participating providers ranged from few practitioners to entire provider groups (networks) with hundreds of physicians. In general, the larger the size of the physician practice or group (network), the more advanced the VBC approaches. Some sophisticate forms of VBC arranged with large medical providers may serve hundreds or even thousands of a plan's members. Forms of VBC that involve sophisticated population health management to facilitate shared savings (and perhaps downside risk) tend to need large patient panel sizes.

Members Impacted and Provider Payments Relative to MCO Capitation

There is an ongoing effort to estimate the number of potential members who may be associated with the new types of payment structures (relative to the total MCO membership in the respective plan) and the amount of money involved (relative to the MCO capitation amount of the respective plan) and the extent to which members may be impacted by the VBC arrangements. Such information can be calculated only when the overall membership and capitation amount of each MCO is known. HHSC is contemplating various evaluation methodologies for calculating VBC penetration rates. One way is to look at the number of members associated with the new types of payment structures. Another way is to evaluate the penetration by analyzing the funding spent in VBC out of the total MCOs revenue. These are complicated endeavors as the financial contractual agreements between MCOs and providers are confidential.

Care must also be taken to choose measures that don't inadvertently mislead rather than inform. For example, one type of VBC can give the impression of a very high rate of penetration with a small bonus on top of a standard FFS arrangement. However, there may turn out to be little positive change as a result of this arrangement. In the meantime a more robust program that targets a smaller population may have greater overall impact on the transformation of health care to a value-based model. One has to consider how all of the VBC efforts blend together and leverage each other, which may require a degree of subjective evaluation. There is a tipping point to be achieved where value overtakes volume and transformation starts to occur.

Common Measures Used

The MCOs generally use recognized quality indicators for determining triggers for incentives:

- Healthcare Effectiveness Data and Information Set (HEDIS) measures (such as well child visits, asthma care, HbA1c, prenatal/postpartum care, breast cancer screening, dental).
- Potentially preventable events like potentially preventable emergency department visits, potentially preventable hospital admissions, potentially preventable hospital

readmissions, potentially preventable hospital complications and potentially preventable ancillary services

- Other administrative-related and accessibility based measures.

Payment Structures

As described by the MCOs, the types of alternative payment structures varied, but generally they were representing the following major combinations:

- FFS with bonus payments for achievement of a specific measure or measures, either for administrative activities (use of electronic health records, for example) and quality outcomes (such as HEDIS scores or lower emergency department use), or access to care (i.e. the practice accepts new Medicaid patients, offers same-day appointment options and/or expanded after-hours/weekend access)
- Partial capitation with or without bonuses for quality improvement and/or bundling of various medical episodes (such as a pregnancy or cardiac care) and various medical home models
- Shared savings approaches based on lowering their patient population total cost of care, reductions/avoidance in ER, admissions/readmissions or pharmaceutical spending.

It must be stressed there is often a combination of different payment models. The same MCO may have a provider receiving, for example, a capitated rate with a shared savings element. Various strengths and weaknesses of these VBC categories are described below.

FFS with Bonus Payments

Purpose: to compensate for achievement of a specific measure or measures, either for better administrative or quality outcomes, or increased access (such as well child visits or other timely visits, or expanded after-hours access). For instance, one MCO pays (among several items) a $10 for each adolescent well child visit, $20 for each prenatal and post-partum visit, and $25 for members with diabetes whose HbA1c (blood sugar level) is kept under control.

Strengths/benefits

- Relatively easy to implement for both the MCO and the provider.
- Can generally be done with administrative data.
- Minimal provider resistance, especially if done with few provider time/labor/resources required.
- Can be done with providers with smaller member panel sizes.
- Can be used to target a measure with special need for improvement, often with a focus on the measures used in the Medicaid-CHIP Pay-For-Quality program. This could include measures like Potentially Preventable Events (PPE) such as ED visits and hospital admissions/readmissions that could have been avoided though better care.

Weaknesses/challenges

- Payment incentives may not be big enough to change behavior. A minimum tipping point may be needed.
- Still rooted in FFS and continues the volume-based model.
- May not lead to notable practice management changes or population health management.
- Providers with very small panel sizes may not have enough numerator size to calculate some measures accurately.

Considerations

- While a straightforward approach is relatively easy to implement, the gains may be minimal without a lot of MCO work with the providers. Practice transformation assistance is important no matter what VBC model is implemented.
- The MCO may place requirements for providers to participate in their incentive program, such as having an open panel (accepting new Medicaid patients) or extended clinic hours. A provider would have to agree to these items as a pre-condition to access the bonus payment program.

Number of MCOs using it

- Very common, as at least ten health plans have adopted this model.
- May be used as a first effort or as part of a suite of incentive programs.

Partial Capitation (+/-) with or without Bonuses

Purpose: Incentivize for quality and/or bundling of various medical episodes (such as a pregnancy or cardiac care) and various medical home models.

Strengths/benefits

- Can generally be implemented with administrative data, but EHR and HIE are often used as leverage
- Can still be done with providers with somewhat smaller member panel sizes. However, the benefits of the model increase as panel size gets larger
- Creates incentives for improved practice management changes and population health management
- If done properly, provides an incentive to manage a population efficiently
- Can be scaled, from relatively small PMPM bonus amounts for simple improvements progressively to advanced models where capitation covers a large portion of the provider's revenue
- Moves away from being rooted in FFS and continues the evolution toward a more complex value-based model

Weaknesses/challenges

- PMPM payment incentives must be significant enough to change behavior
- The provider must commit to the work involved in implementing the model. This is a major change in how their practice operates
- Providers with very small panel size of members may not have large enough numerators to calculate some measures accurately
- MCOs may have difficulty doing the practice transformation work with providers with small panel sizes. The health plans need a certain critical mass of members to justify the resources involved
- May be faced with more provider resistance and require much more provider time/labor/resources to do effectively
- Can require much more involvement to implement from both the MCO and the provider

Considerations

- Practice transformation assistance from MCOs becomes very important as providers move to capitation
- MCO must commit to supporting the model with actionable data for providers to manage a population
- Capitation can be coupled with shared savings
- Requires multiple considerations on the part of the MCO when establishing the capitation for providers and the expectations involved for earning it

Number of MCOs using it

- Not as common, though growing, at least six plans have implemented it.
- There are regions of the state with greater penetration of this model, such as in the Nueces area.

Shared Savings Approaches

Purpose: Compensation based on lowering total cost of care, reductions/avoidance in ER, admissions/readmissions or pharmaceutical spending

Strengths/benefits

- Can generally be implemented with administrative data, but EHR and HIE are often used as leverage. ADT feeds are seen as highly important. This model requires permanent data flow
- Can be done with providers with somewhat smaller member panel sizes. However, the benefits of the model increase as panel size gets larger

- May create the strongest incentives for improved practice management changes and population health approach
- When done properly, may create the highest incentive to manage a population efficiently
- The amount of shared savings in play and what counts for/against the calculation can be customized. It can vary from simple structures all the way to ACO (like) arrangements
- Moves away from being rooted in FFS and continues the evolution toward a complex value-based model

Weaknesses/challenges

- The shared savings amounts must be significant enough to change provider behavior
- The provider and the MCO must both commit to the work involved with leveraging this model to maximize the benefits
- Providers with very small panel sizes may not have large enough numerators to calculate some measures accurately
- MCOs may have difficulty doing the practice transformation work with providers with small panel sizes. Health plans need a certain critical mass of members to justify the resources involved
- May be more provider resistance and may require much more provider time/labor/resources to do it effectively. The upside of greater revenue has to offset the additional time/labor/resources required

Considerations

- Practice transformation assistance from MCOs becomes very important as providers move to a shared savings model
- MCO must commit to supporting the model with actionable data for providers to manage a population
- Shared savings can be coupled with capitation
- Requires a lot of consideration on the part of the MCO when figuring out the shared savings for providers and the expectations involved for earning it
- HHSC may also have a greater role in data sharing through efforts like the ongoing hospital admissions-discharge-transfer (ADT) feeds project. Timely data is critical to a population-health management model

Number of MCOs using it

- Not as common, though growing, as at least six plans have embraced this model. How common it is really varies by how mature the model is at the time of deployment. Simple shared savings approaches are more common, though ACO arrangements also growing. Since the practice is only at risk for additional revenue through the shared savings, the practice is only sharing in the upside risk.
- Mostly lends itself to large multi-specialty practices with substantial panel sizes. However, may also be used with large single specialty practices, such as Ob/Gyn.

Summary of Common Considerations for VBC Models

- Regardless of the model chosen, there must be a sufficient incentive or disincentive (i.e. a tipping point) to change provider practice management/behavior. This may vary by the provider type, region, or other considerations.
- Gains may hinge as much on the support/collaboration between the MCO and the providers as much as on the specifics of the model. As the MCO and provider's VBC relationship matures, there is a fundamental change in how they do business together. An MCO is no longer just paying a provider, as the provider is now the MCOs partner. A trusting relationship and continuous dialogue between payers and providers is critical to success.
- The switch to a value-based model has implications for HHSC, ranging from MCO capitation rate calculation to selection/use of quality improvement measures. HHSC may have a role in facilitating data sharing, promoting best practices, researching outcomes, and the development of quality measures that mesh with a health plan system. Of particular importance is ensuring that success in payment reform is rewarded and not penalized.
- A larger issue is that MCO rate-setting is still built largely on paying for member's medical care (i.e. paying for illness). The Legislature, stakeholders and HHSC will have to contemplate on what a future Medicaid-CHIP financial system that pays for optimizing "health" looks like when setting MCO payments and moving toward better systems of care.
- As VBC models mature, there is a growing awareness of a combination between medical care and social services for the Medicaid-CHIP beneficiaries. The managed care industry and the Medicaid-CHIP Program are grappling with how to reconcile the needs of a whole person with the current health care approach which seem fragmented. This issue is common across multiple states and is also on CMS's radar. This has implications for multiple business units in the State Health and Human Services System.
- An advantage Texas has is a large number of Delivery System Reform Incentive Payment (DSRIP) projects and a well-organized set of Regional Healthcare Partnerships within the healthcare transformation initiated by the 1115 Waiver Demonstration Project. DSRIP helps create a collaborative atmosphere that could help advance VBC. The efforts underway in various RHPs to bring MCOs and DSRIPs together are promising. The RHP infrastructure helps support these efforts.

Conclusion

All MCOs and DMOs providing services to members in Texas' Medicaid-CHIP programs have some level of VBC with their providers. While the VBC efforts may vary in size and scope across the MCOs, the evidence is clear the Texas Medicaid-CHIP market is continuously shifting towards outcomes-based payments. This creates changes in how plans and providers work together (payer vs. partner), the mindset (population health management vs. individual patient encounters), and the overall goals of the health care system (largely acute sick care vs. promoting prevention and better overall health).

VBC creates a shift in the health care system statewide on par with the transition from FFS to managed care as a model for the Medicaid-CHIP population. It impacts Medicare, Medicaid-CHIP, commercial insurance, and quite literally everyone else in the health care industry. While a VBC model shows great promise, it is a complex endeavor.

However, the potential is there for genuine improvement that meets the much-sought triple aim of health care: improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care.